CHAPTER 33

ROYAL NAVY RECOVERY PATHWAY (RNRP) POLICY

(Sponsor: NAVY PEOPLE-PS RRM SO1)

CONTENTS

Para

3301. Introduction
3302. Aim
3303. Command and Control
3304. RNRP Entry and Exit Criteria
3305. Personnel on Recovery Duty Definition
3306. Assignment Considerations
3307. Chain of Command for WRTM Organisations
3308. The Individual Recovery Plan (IRP)
3309. Overview of the IRP
3310. JPA Record of the IRP
3311. Divisional Responsibilities
3312. Recovery Activity and Personnel Recovery Centres (PRCs)
3313. Employment
3314. Participation in Adaptive Sport and Adventurous Training
3315. Home Adaptations
3316. Recovery Staff Training
3317. Supervision
3318. Assurance
3319. Medical Discharge Policy
3320. Medical Assessment Process
3321. Transition Pathway
3322. Resettlement Policy

ANNEXES

Annex 33A: Overview of the Royal Navy Recovery Pathway
Annex 33B: Workforce Resilience and Training Margin Organisation Contact Details
Annex 33C: Assignment Considerations for Personnel on the RNRP
Appendix 33C1: Case Conference Process - Complex Cases
Annex 33D: Individual Recovery Plan (IRP)
Annex 33E: Core Recovery Events and the Recovery Activities Programme
Annex 33F: Participation in Recovery Events and Activities
Annex 33G: Transition Assessment Form.
Annex 33H: Naval Reserves Recovery Pathway

CHAPTER 33

ROYAL NAVY RECOVERY PATHWAY POLICY

3301. Introduction

The Defence Recovery Capability (DRC) is designed to deliver a conducive military environment within which all serving personnel on their single Service Recovery Pathway receive the appropriate support to enable an effective Return to Work (RTW) or transition to a properly supported and appropriately skilled civilian life[1].

3302. Aim

The purpose and policy of the Royal Navy Recovery Pathway (RNRP) seeks to achieve the following:

a. Provide the Chain of Command and the Service Person with a guideline of activity and considerations from the point of entry to the point of exit on the RNRP.

b. Support individuals to achieve their maximum recovery potential in order that their continued service can be effectively assessed.

c. Inform the Executive decision-making process[2] on whether an individual should be retained or discharged.

d. Deliver equity and ensure the commonality and consistency of the RNRP experience.

e. Deliver an optimised outcome through a patient focused approach to recovery.

3303. Command and Control

a. Director Personnel and Training ‘owns’ the RN Recovery Capability and is a member of the Defence Health and Wellbeing Board (DHWB).

b. Deputy Director People Delivery (DDPD) is responsible for RNRP policy, governance and assurance, which is delegated to Hd People Support.

c. Day to day management of RNRP policy, governance, assurance, direct line management of Royal Navy Recovery Centre (RNRC) Hasler and delivery of the RN recovery programme is delegated to SO1 Recovery and Resilience Margins who also acts as the RN member of the Defence Recovery Task Group (DRTG), reporting to the DHWB.

d. Recovery is a command-led activity which is authorised by a CO in order to ensure that the Royal Navy fulfils its duty of care responsibility towards its personnel on the RNRP. The Parent Unit[3] retains Command of all personnel on the RNRP.

[1] JSP 661 Health and Wellbeing. Section 2.
[2] Royal Navy Medical Employability Board (RNMEB).
[3] The ‘Parent Unit’ is the Unit to which the RN/RM individual is assigned.

3304. RNRP Entry and Exit Criteria

a. The Royal Navy Recovery Pathway (RNRP) is the term used to describe the journey a Service person takes from the point of injury or illness to the point where they either return to work (RTW) fully upgraded, RTW in a permanently limited Joint Medical Employment Standard (JMES), or they leave the Service due to medical discharge or other reasons[4]. This policy is to be used as a handrail to support all trained strength regular RN personnel who have a temporary JMES of M-3, 5 or 6 or L-3, 4, 5 or 6 (or simplistically, those personnel who are medically unfit to go to sea or undertake operational tasking in the RM). For Untrained Strength (UTS) personnel, the entry criteria for the RNRP is having a temporary JMES of M-3,5 or 6 or L-3,4,5 or 6 AND they have been temporarily withdrawn from training because of this. Variance in application of this policy for UTS personnel is highlighted throughout this Chapter. A summary of the RNRP is at Annex 33A.

(1) **RNRP Entry Criteria.** Regular GTS SP awarded temporary JMES of M-3, 5 or 6 or L-3, 4, 5 or 6. Regular UTS Service Person awarded temporary JMES of M-3, 5 or 6 or L-3, 4, 5 or 6 AND temporarily withdrawn from training because of this.

(2) **RNRP Exit Criteria.** When the regular GTS SP is upgraded to M2 or above, assigned to a Workforce Requirement driving role having been awarded a permanent JMES at RNMBOS and retained at RNMEB, or final date in Service.

b. Many units have personnel from the Army and RAF serving within. It should be noted that each Service has a different Recovery Pathway 'entry' criteria and single Service (sS) policy[5] should be consulted to ensure appropriate support is afforded to the individual.

c. Rehabilitation and Recovery are two distinct, but complementary, processes. Rehabilitation is primarily clinical treatment for medical conditions arising from wounding, illness or injury and is the responsibility of the Surgeon General (SG). Recovery is primarily a non-clinical activity, but may involve individuals undergoing rehabilitation, and is designed to assist personnel to return to duty or prepare them for life outside the Armed Forces. Recovery is the responsibility of the Chief of Defence People.

[4] Which may be naturally reaching the end of a person's Service, TX following submission of notice or other premature release such as discharge SHORE, SNLR or via disciplinary means.
[5] Army: AGAI Vol 3 Chap 99 'Command and Care of Serving Personnel on Recovery Duty'; RAF: AP7005 Leaflet 502 'Management of RAF Personnel on Long-Term Sickness Absence'.

3305. Personnel on Recovery Duty Definition

The term 'Personnel on Recovery Duty' (PRD) refers to those personnel on the RNRP who are unable to undertake their *normal* duties. In the RN, this applies only to personnel who are assigned to an MA7A medical margin within a Workforce Resilience and Training Margins (WRTM) organisation such as a Personnel Support Group (PSG), Recovery Troop (RT) or Royal Navy Recovery Centre Hasler (RNRC Hasler). The majority of personnel on the RNRP do not need to be assigned to an MA7A margin if they can either remain in their current role or be assigned to another role compatible with their temporary JMES and Medical Limitations (MEDLIMS).

Note. *Pregnant Service Personnel given a JMES of E6 who also receive a JMES of M-5 are not to be considered as being on the RNRP and will not be identified as such via SCIO.*

3306. Assignment Considerations

a. When a Service Person (SP) enters the RNRP, the Line Manager (LM), (usually the Divisional Officer (DO) or Troop Commander (Tp Cdr)), needs to consider whether the current assignment is the most appropriate place to support the individual's recovery or whether assignment elsewhere is required. Throughout this process, the individual must be involved to ensure their preferences are considered and they are engaged in and understand the decisions made.

b. Most individuals either remain in their unit from point of downgrade or are assigned to another workforce requirement driving position elsewhere vice being assigned to one of the 12 WRTM organisations below[6] (contact details in Annex 33B):

(1) **PSGs in:** HMNB Devonport, Portsmouth and Clyde, RNAS Culdrose and Yeovilton.

(2) **RTs in:** 40, 42 and 45 Cdo, CLR, and Hamworthy Barracks. Assignment to MA7A within CTCRM can also be considered..

(3) **RNRC Hasler.** For most complex medical cases.

c. All personnel on the Recovery Pathway are individuals facing different illnesses and injuries, different clinical pathways and treatment options, different career freedoms and constraints and different personal circumstances. Their lives and careers preceding their recovery journeys are all different too; all of which means no single process or model works for all. There is however a framework of policy that is designed to balance the optimal needs of the individual with the needs of the Service; both needs focus on enabling the individual to become as well as possible to either return to work or leave the Service as well as possible.

[6] RN and RM can be assigned to any of the WRTM organisations if deemed appropriate.

d. The following is a brief outline of employment and assignment considerations at the point of downgrade or JMES change for GTS SP. More detail is provided at Annex 33C.

Step 1 - JMES Change Temp M-3,5,6 or L-3,4,5,6 for more than 3-months.
Step 2 - Employment Considerations - tenable to remain in role? If yes, support recovery and re-assess at JMES review. If no, go to Step 3**.**
Step 3 - Assignment Considerations - alternative workforce requirement driving role or MA7A in WRTM organisation? If PSG or RT is appropriate, follow the extant RNTM for joining instructions to a PSG or RT. If complex or no agreement with WRTM OC, go to Step 4.
Step 4 - Case Conference request for RNRC Hasler consideration. Complete Appendix 33C1 and submit to NAVY PEOPLE-PS RRM SO1. If assigned, conduct DO handover as arranged with Hasler staff. If not, follow extant RNTM for PSG/RT assignment.

e. For UTS personnel on the RNRP, the default is that the SP remains within the Chain of Command of their current training establishment. If at discussion at the unit Carer's/N1 forum, it is decided the case requires specialist support and/or is likely to be long-term, this is to be discussed with the most relevant WRTM organisation who can make a decision on assignment to their medical margin. The training establishment CO must agree with the receiving unit CO and record this decision in the training establishment's CO's risk assessment. Training establishments and WRTM organisations are to include this process in their Supervisory Care Directive. UTS considered for RNRC Hasler are to be managed the same as GTS regarding assignment only after a case conference.

3307. Chain of Command for WRTM Organisations

a. The Chain of Command for WRTM organisations is:

Unit	OC	CO	HA
PSG HMNB Clyde	SO2 PSG OC	Capt SM	Dir SM
PSG HMNB P'mouth	SO2 PSG OC	COB P	NBC P
PSG HMNB D'port	SO2 PSG OC	COB D	NBC D
PSG RNAS Yeovilton	WO1 PSG OC	RNAS CO	Dir FGEN
PSG RNAS Culdrose	WO1 PSG OC	RNAS CO	Dir FGEN
40 Cdo	WO1 RT OC	40 Cdo CO	CO HQ CF
42 Cdo	WO1 RT OC	42 Cdo CO	CO HQ CF
45 Cdo	WO1 RT OC	45 Cdo CO	CO HQ CF
CLR	WO1 RT OC	CLR CO	CO HQ CF
Hamworthy Barracks	WO1 RT OC	CO	DSF
RNRC Hasler	SO2 OC	OC/COB Devonport[7]	Dir P&T
CTCRM	WO1 PRD Mgr	Comdt CTCRM	Dir P&T

b. Whilst RRM SO1 does not have a Command function for WRTM organisations with the exception of RNRC Hasler, they are responsible for WRTM organisation operations within the pillars of administration; divisional; employment, and recovery activity articulated and assured via standardised operating procedures[8].

[7] RNRC Hasler is CO – for disciplinary and administrative action above authority of SO2, COB Devonport delivers this capability.
[8] Within the Recovery and Resilience Margins HQ Playbook within People Support.

3308. The Individual Recovery Plan (IRP)

a. Everyone who meets the criteria of being in the RNRP should have an IRP no later than 90 days of being eligible. The IRP is the Executive tool the individual and their DO or Tp Cdr use to optimise the conditions and environment whilst the individual is undergoing treatment for ill-health or injury. The IRP template is at Annex 33D. It is not designed to be cumbersome but the initial information reference JMES is important to consider if workplace adjustments are required and review dates give timelines to factor in.

b. The IRP is designed to support SP in achieving a successful recovery outcome. When completed it will provide a good understanding of activities taking place and appointment timeframes which are in the best interests of the SP. The IRP is to be developed by the SP according to the complexity of their case and be regularly updated with the assistance of the DO or Tp Cdr and other specialist staff. Whilst the IRP is owned by the SP and is central to managing their expectations of recovery and assisting them in forward planning for their recovery activities, the DO/Tp Cdr is responsible for raising it at the appropriate point and guiding the SP throughout their time in the RNRP. It should be tailored to the needs of the individual, incorporate their clinical activities (which take precedence), and designed to help prepare the SP for their potential or expected outcome. The IRP should always be within the SP's clinical boundaries.

c. Whilst the entry point of the RNRP is also the point at which an IRP should be considered, it may sometimes be appropriate for the qualifying JMES to be awarded for a short period of time with reasonable expectation of returning to JMES M1 (medically fully deployable) within 3 months. For this reason, for personnel who meet the entry criteria for the RNRP, an IRP **CAN** be raised as soon as this happens where there is a reasonable expectation this will extend past 90 days. However, all personnel who meet the entry criteria for the RNRP with a JMES review date of more than 90 days, or **no later than 90 days** after first being awarded the JMES, an IRP **MUST** be raised.

d. Once an IRP has been discussed and created between the SP and DO/Tp Cdr the document must be kept as a "live" document. The IRP is to be regularly updated (minimum monthly) to track the SP's progress. The IRP is only to be finalised and sent for archive when the SP has reached the exit criteria as detailed in para 3304.

e. To send the IRP to archive, the file should be named in the format**:** **YYYYMMDD-IRP_SERVICE NUMBER_RANK_SURNAME-FINAL-OSP** and sent to NAVY PEOPLE-PS RRM IRP (NAVYPEOPLE-PSRRMIRP@mod.gov.uk). If a SP is assigned to another unit whilst still in the Recovery Pathway, the IRP should be forwarded by the losing DO to the new DO as part of the divisional handover.

JMES Status	IRP Requirement
Sick on Shore	No, if under 2 weeks duration. Mandated if over 4 weeks when SP should be graded M6, L6.
Perm JMES M2,3,5 or L2,3,4,5	No, unless awarded Perm JMES for 1 year by OH or MBOS for rehabilitation purposes[9].
Temp JMES M3,5,6 or L3,4,5,6 (day 1-90)	Not mandated for those likely to be upgraded MFD within 90 days but can raise IRP immediately if likely to remain longer than 90 days.
Temp JMES M3,5,6 or L3,4,5,6 (at 90 day point)	Mandated
Perm JMES M1,2 or L1,2	No

f. Defence Primary Health Care (DPHC) is responsible for the delivery of Occupational Health (OH) for Maritime Reserve (MR) personnel irrespective of Terms and Conditions of Service. DPHC is to provide OH assessments to establish the Joint Medical Employment Standard (JMES) of MR to inform of their employability and deployability (if relevant). MR are required to inform their Chain of Command of any condition that affects their ability to carry out their duties (there is no requirement to disclose the details of any condition or injury) and attend a military OH medical assessment at their Unit or nearest Medical Centre. All downgraded MR are to have an IRP drafted after assessment by their Divisional Officer. This will allow the individual and unit executive to discuss the implications of the injury or illness on employability and deployability, as well as signposting any support that may be required. Should the MR be injured on duty, evidenced by a MOD Form 510 or equivalent, the individual is entitled to Service rehabilitation support.

3309. Overview of the IRP

a. Annex 33A gives a broad timeline of the RNRP and the various Executive considerations SP and their DO/Tp Cdr should be aware of. Whilst clinicians will not share any medical in confidence information, if the DO/Tp Cdr needs to consult with the MO/physio/ERI/DCMH, RN FPS etc to ensure the support to the SP is joined up, share relevant information or ask for clarification on any point, the Unit N1 forum is the mechanism to do this. The IRP must not contain any medical in confidence information.

b. For all SP, not just those in the RNRP, the Life Checker is a very useful tool for SP and their DO's/Tp Cdrs. If a SP identifies a concern in any aspect of their life, the Life Checker will signpost them to relevant information and guidance. More guidance is within RNTM 01-004/24.

c. There is no 'standard' for recovery; illness and injury affect every individual differently. This policy offers a framework but if you have any concerns about your own recovery pathway or that of someone you are supporting, either contact your local PSG, RT or RNRC Hasler whose contact details are at Annex 33B, or the Recovery and Resilience Margins HQ.

[9] Typically awarded to allow 1 year of musculoskeletal or mental health rehabilitation and will require IRP.

3310. JPA Record of the IRP

a. To create an audit trail that an IRP has been raised, the UnitAdministrator/Department Co-ordinator (DEPCO) is to raise a JPA competency (with no end date):

Welfare|Individual Recovery Plan|Joint.

The DO/Tp Cdr should notify the relevant person in their organisation that the IRP has been raised so this action can be taken.

b. When an IRP has been created it must remain a "live" document between the DO/Tp Cdr being regularly updated and stored in a secure area in line with GDPR. It is only to be considered finalised and sent for archive when the SP has met the criteria for exiting the Recovery Pathway (as detailed in para 3304).

c. When the SP meets the exit criteria for the RNRP, the IRP competence is to be end dated in JPA, **not** deleted.

3311. Divisional Responsibilities

a. A member of the RN should not be sick-on-shore for longer than 14 days before a JMES change is considered. For personnel sick-on-shore, the DO/Tp Cdr/LM should establish communication as soon as possible to establish their support need. For personnel awarded a JMES of M or L-6, the DO/Tp Cdr is to establish contact[10] as soon as possible but no later than within 10 days and maintain contact every week to exercise appropriate duty of care to the individual and ensure they feel like they are still part of the unit and being appropriately supported. A home visit should be conducted by day 21 and regularly thereafter. If the SP will not agree to a home visit or it is decided by the individual AND DO/Tp Cdr/LM that a home visit is not required or appropriate or the periodicity should be changed, this should be recorded in the IRP. The method of regular contact e.g. Skype, telephone call etc. is to be recorded.

b. Where RN personnel are being treated for protracted or complex injuries or illnesses through the Royal Centre for Defence Medicine (RCDM), Defence Medical Rehabilitation Centre (DMRC) or any other hospital, the Parent Unit remains responsible for the individual's overall management and recovery. If a unit is unable to provide appropriate divisional care for any reason, they are to consider assignment to or temporary support from a PSG or RT and must contact the relevant unit at Annex 33A to formally agree this in writing.

c. The Recovery Pathway combines a multi-disciplinary Executive, Medical, Welfare and Pastoral support service under the overall co-ordination of the Chain of Command drawing support from the Third Sector[11]as required.

[10] In person, by telephone or email. A record of all contact made, and discussions had, are to be recorded by the DO.
[11] 3rd Sector support includes DRC strategic partners, The Royal British Legion (TRBL) and the RNRM Charities.

d. The Recovery Pathway must not be regulated by set timelines. There is no pressure for unseemly haste but those on their recovery pathway should strive for positive milestones. Those managing the recovery pathway for individuals must ensure that key events identified in the IRP are being met, preventing unnecessary drift for, or by, the individual. Whether operational or non-operational, on duty or off duty, where and how an individual finds themselves on the Recovery Pathway is irrelevant. It is there to guide those that need support and includes those with psychological as well as physical injury or illness.

e. Each SP must be encouraged to take control of their own recovery 'journey', set and record clear goals and take 'ownership' of their IRP. The Recovery Pathway is their 'place of duty' and those who do not engage and habitually 'Do Not Attend' appointments, meetings, recovery activities, etc should be subject to Minor Administrative Action (MAA) and the Warning process for Discharge Shore (Inadequacy) as outlined in Chapter 57, noting the particular circumstances of the case.

f. If an optimum outcome is to be achieved, transparency between the executive, the medical and the individual is essential throughout the Recovery Pathway. In any discussions, however, care should be taken to protect personal data, and all involved should be cognisant of the Defence Medical Caldicott Policy[12], noting that sharing certain information can be beneficial to the Service Person (SP) (Principle 7[13]).

g. Personnel within the RNRP are to be formally assessed throughout recovery to ensure that the IRP is delivering the required outcome. If progress is not being made, the case is to be brought to the Unit Carer's/N1 Forum and discussed within a multi-disciplinary team of SMEs.

h. All personnel on the RNRP *likely* to be discharged from the RN on medical grounds can access resettlement entitlements at an earlier stage than other Service Leavers[14]. In these cases, a balance needs to be retained between recovery and resettlement activities to ensure that the SP has sufficient time to plan for the future and is ready for transition to a properly supported and appropriately skilled civilian life.

i. All personnel, regardless of where they are and how long they have been on the 'Recovery Pathway', are entitled to an SJAR/OJAR; UTS should be managed according to their individual circumstances, minimising non-reporting as much as possible. Often, SP are sick on shore or employed in restricted activities not associated with their rank or specialisation for a prolonged period; in these instances a Short Appraisal Report (SAR) may be more appropriate[15]. The SAR should contain sufficient detail to describe the nature of the recovery duties/activities undertaken and the attitude of the SP/PRD in engaging in the recovery process. In cases of doubt, the appropriate Promotions Branch Secretary should be consulted.

---

[12] JSP 950 Vol 1, Ch 2, Leaflet 1-2-15.
[13] Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.
[14] JSP 534 Section 6.
[15] JSP 757 Part 2 Vol 1 Chap 1 Annex B Para 1.a (6).

3312. Recovery Activity and Personnel Recovery Centre's (PRCs)

a. Recovery is different for all; it can be a lengthy process with intense periods of treatment and rehabilitation interspersed with periods of inactivity, or it can be very straightforward and uncomplicated where the SP can be gainfully employed between medical interventions in unit. Either way, appropriate support to enable an effective return to full duties or transition to a properly supported and appropriately skilled civilian life is to be provided and there are numerous approved recovery activities that can be utilised to contribute to these goals.

b. All GTS personnel on the RNRP are entitled to undertake recovery activities which can take many forms from yoga and wellbeing retreats to chainsaw courses. Currently UTS personnel on the RNRP AND assigned to a medical margin in a WRTM organisation, are entitled to undertake RN delivered recovery activities only with access to Defence delivered recovery activities approved by exception via the RRM HQ. Participation in a recovery activity must be coherent with the IRP and be programmed so as not to impact upon, but work in conjunction with, planned clinical and rehabilitation activities.

c. Before attending any recovery activity/course, a formal discussion is to be made by the SP on the RNRP to their CoC to ensure activity/course is suitable in accordance with the SP JMES codes. Once confirmed, a course application form, found on the RRM HQ SharePoint page, is to be submitted to the Area Recovery Manager or POC for specific activity/course.

d. There are a number of Defence Recovery courses available at Personnel Recovery Centres (PRCs), which are of benefit to RN SP on the RNRP not necessarily just those preparing to leave the service. More detail is at Annex 33E.

e. The RN Recovery Programme, alongside the Defence Recovery courses can be found on the RRM HQ SharePoint page[16].

f. DO's/Tp Cdrs and SP are to note that all personnel who meet the RNRP entry criteria are eligible to undertake a Recovery Activity. It must be recorded in the IRP and be a DRC or RRM approved recovery activity to convey duty status.

g. Within the Recovery Activity calendar there are Overseas Activities, which are coordinated by SO3 RRM HQ. These are advertised separately with participant selection conducted via application form and sift. Overseas activities also require WRTM staff to attend in order to safeguard SPs. Request for staff member volunteers is sent out by SO3 RRM HQ.

[16] https://modgovuk.sharepoint.com/teams/61893/SitePages/Recovery-Courses.aspx.

3313. Employment

a. All employment undertaken by SP on the RNRP must be cognisant of the individual's medical limitations and, where any doubt exists, clarification should be sought from the MO. Those SP on the RNRP who are defined as PRD (i.e. on the RNRP and assigned to an MA7A medical margin within a WRTM organisation), should be afforded appropriate temporary gainful employment as afforded by their JMES.

b. Being suitably employed and feeling a valued member of the RN is a fundamental part of recovery, but it should not come at the expense of rehabilitation. Employment during recovery should be considered alongside other recovery activities however, the primary 'duty' of a PRD individual is rehabilitation.

c. For the majority of RN SP on the RNRP, particularly those who are PRD, return to duty is the expected recovery outcome. In order to achieve this, a Gradual Return to Work (GROW) programme is often required and employment should, where possible, be tailored towards the trade/skill of the SP.

d. When an individual is nominated for a period of employment, it should be noted in the IRP. The employing officer should be made aware of any restrictions and limitations in place and the requirement to attend rehabilitation/medical appointments[17]. Whilst the employer may have day to day line management responsibility for the PRD, they may not have divisional responsibility; this is to be made clear to all parties and the IRP annotated accordingly.

e. PRD are entitled to an OJAR/SJAR and temporary employers are to feedback sufficient information to the DO/Tp Cdr/1RO in order for a report of value to be drafted.

f. PRD who are recommended for Royal Navy Medical Board of Survey (RNMBOS)[18] discharge should consider registering for resettlement at least 4 months before the point of referral[19]. In these cases, any temporary employment should be considered alongside the need to commence resettlement activity and registration with the Career Transition Partnership (CTP).

3314. Participation in Recovery Events and Activities

Participation in Recovery Events and Activities could accelerate the recovery of a SP on the RNRP. More detail is at Annex 33F.

[17] Subject to DPA and Caldicott Policy requirements.
[18] JSP 534 Section 6.
[19] Usually 12 months after the initial downgrade i.e. consider registering for resettlement 8 months after downgrade if expected to remain downgraded at 12-month point.

3315. Home Adaptations

SP with complex injuries may require adaptations to domestic accommodation[20]. Adaptations can be made to SLA, SFA, private homes (including parental homes) and adaptations to a second property when SP personnel move from an adapted parental home to their own property. The process is initiated using a Service Adaptation Initial Case Report (SAUCER); this form provides the background and includes an Occupational Therapist (OT) assessment. It is important that SP requiring private home adaptations start the process as soon as possible to allow sufficient time for the application process and completion of work[21]. Funding for home adaptations for serving SP is a DIO responsibility. Further advice may be obtained from NAVYLOGINFRA-INFRASTRAT1@mod.uk.

3316. Recovery Staff Training

The management and oversight of RN personnel on the RNRP and particularly PRD within WRTM organisations, can often be a difficult, time consuming and emotionally taxing, especially when dealing with multiple cases. In order to better prepare personnel for an assignment in a WRTM organisation, training requirements are within the RRM HQ Playbook. WRTM organisation OCs are responsible for ensuring their staff have undertaken the mandatory training.

3317. Supervision and Caring for the Carers

The intense involvement with SP on the RNRP can result in the physical, psychological and emotional exhaustion syndrome of burn-out. To ease this potential risk, a supportive supervision model is required to manage the complex demands of the work undertaken by personnel working within the WRTM organisations. The group supervision process is detailed in the RRM HQ Playbook.

3318. Assurance

a. The Defence Health and Wellbeing Board, through Director People and Training and the Naval Secretary, requires confidence that the Royal Navy Recovery Pathway (RNRP) is being carried out in accordance with policy and is delivering the required outcomes for RN personnel. This will be achieved by conducting a series of Assurance Visits to RN Units and Establishments and will be delivered initially through a two-year rolling programme.

b. The primary responsibility for delivering the RNRP lies with the Unit Executive through the Divisional/RM Company system or, in those units that have them, through PSGs, RTs or RNRC Hasler.

c. The unit Executive Department is responsible for assurance of the RNRP of those assigned to it. The unit Carers' Forum is the conduit through which individual cases are assessed and managed within the unit in a multi-disciplinary environment.

d. External Assurance of any RN unit, not only specialist Recovery Units including Royal Navy Recovery Centre (RNRC), PSGs and RTs, will be conducted by Recovery and Resilience Margins HQ in accordance with the RRM Playbook.

[20] JSP 464 Vol 1 Part 1 Chap 3 Annex C.
[21] Completion of an OT assessment, submission of a business case and the processing of the application for complex cases can take several months to complete.

3319. Medical Discharge Policy

a. Medical Discharge policy for the RN is consistent with tri-service policy[22] and is as follows:

> "Advice to the Royal Navy on the medical fitness of an individual is provided through the award of a Joint Medical Employment Standard (JMES)[23]. The JMES is then used to inform the decision by the Royal Navy on whether that individual should be retained, if the functional ability associated with their medical condition permits, or whether their condition precludes future employment, in which case the Service will arrange for termination of their service. Each case is considered on its merits, so that in some circumstances a small number of those with significant disabilities may be retained, if they wish to be retained, and the Service has a suitable position for them."

b. In order to deliver the necessary consistency of outcome, the CoC shall determine if the right decision is for an individual to leave the RN by the answers the 5 questions[24] below:

(1) What is the individual's Permanent Medical Category?

(2) What is the individual's employability within the Service?

(3) Has the individual's treatment been optimised or reached a plateau?

(4) Has resettlement, training and education been completed?

(5) Is society ready to receive the individual?

[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480979/FOI_04718-JSP_770__Final_v10-U.pdf
[23] BRd 1750A Handbook of Naval Medicine Standards
[24] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480979/FOI_04718-JSP_770__Final_v10-U.pdf.

3320. Medical Assessment Process

a. Specific detail and guidance on the role of the RNMBOS and the Royal Navy Medical Employability Board (RNMEB) is at Chapter 28 and BRd 1991 Chap 8 The RNMBOS assesses the medical state and prognosis of an individual and is conducted once they have been in a reduced medical category for 12 months, or sooner if it is obvious that the PRD will not return to their former grading. The RNMEB decides, based on RNMBOS and Personnel Branch information, whether an individual should be retained or medically discharged from the Service. Retention is gauged on the ability of the RN to offer meaningful and fulfilling employment to injured personnel with realistic prospects of further promotion and advancement for the remainder of their career. The decision of the Board is also informed by an individual's written personal statement and reports by their lead clinician and chain of command.

b. No one will leave the Armed Forces until they have reached a point in their recovery, however long that takes, where leaving the Service is the right decision. In the context of this statement, the RN has determined that the '*point in their recovery where leaving the Armed Forces is the right decision'* will be when an individual's medical care can be transferred seamlessly from Defence Medical Services (DMS) to the National Health Service (NHS) without harm to the individual. If personnel are undergoing specialist medical rehabilitative care, their need for DMS-specific care vice NHS care must be assessed in order that retention in Service[25] or onward referral can be arranged.

3321. Transition Pathway

a. When, due to service limiting injuries, an individual is unfit for continued military service and has gone through the RNMBOS and RNMEB processes, the RN has a responsibility to ensure that the individual's transition to civilian life is managed as smoothly as possible. The principles of clinical transition for all Service Leavers are in JSP 950 Leaflet 1-3-4[26] Additional advice and guidance on the transition of more complex PRD personnel who may require NHS continuing healthcare arrangements (CHC) is described in JSP 770 Chapter 5 Part 4.

[25] Retention until fit to transfer to NHS.
[26] https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FIntranetUKStratCom%2FShared%20Documents%2FJSP%20950%20Leaflet%201%2D3%2D4%20HC%20Transition%20arrangements%20for%20Military%20Personnel%20leaving%20DMS%20care%20%28v1%2E2%20Sep%2021%29%2Epdf&parent=%2Fsites%2FIntranetUKStratCom%2FShared%20Documents

b. Defence Transition Services (DTS) and Veteran Welfare Support (VWS) provide ongoing support, guidance and information to service leavers and their families on issues that will endure beyond discharge. DTS and VWS support is available irrespective of the reason for discharge and is available to regular, reservists and their families. Referrals into DTS/VWS are made using the Defence Transition Referral Protocol (DTRP) detailed in JSP100 part 2[27]. This can be made on behalf of the SP or family member by any responsible tri-service military authority, or by the individual SP or family themselves through self-referral. Integrated Personal Commissioning for Veterans (IPC4V) Framework is a personalised care approach for the small number of Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions resulting from injury whilst in Service to ensure they are effectively cared for and supported as they transition to civilian life and beyond. Individuals who are eligible for IPC4V are proactively identified by medical staff while they are on the Defence Recovery Pathway. Further information is available in JSP 661[3] Chapter 4.

3322. Resettlement Policy

a. All SP on the RNRP *likely* to be discharged from the RN on medical grounds are able to access resettlement entitlements at an earlier stage than other Service leavers[28]. In these cases, a balance needs to be struck between recovery and resettlement activities to ensure that the SP has sufficient time to plan for the future and is ready for transition to a properly supported and appropriately skilled civilian life.

b. In all cases, a Transition Assessment Form (TAF)[29] is to be completed for the PRD and forwarded to the local Naval Resettlement Information Officer (NRIO). The TAF can also be found at Annex 33G.

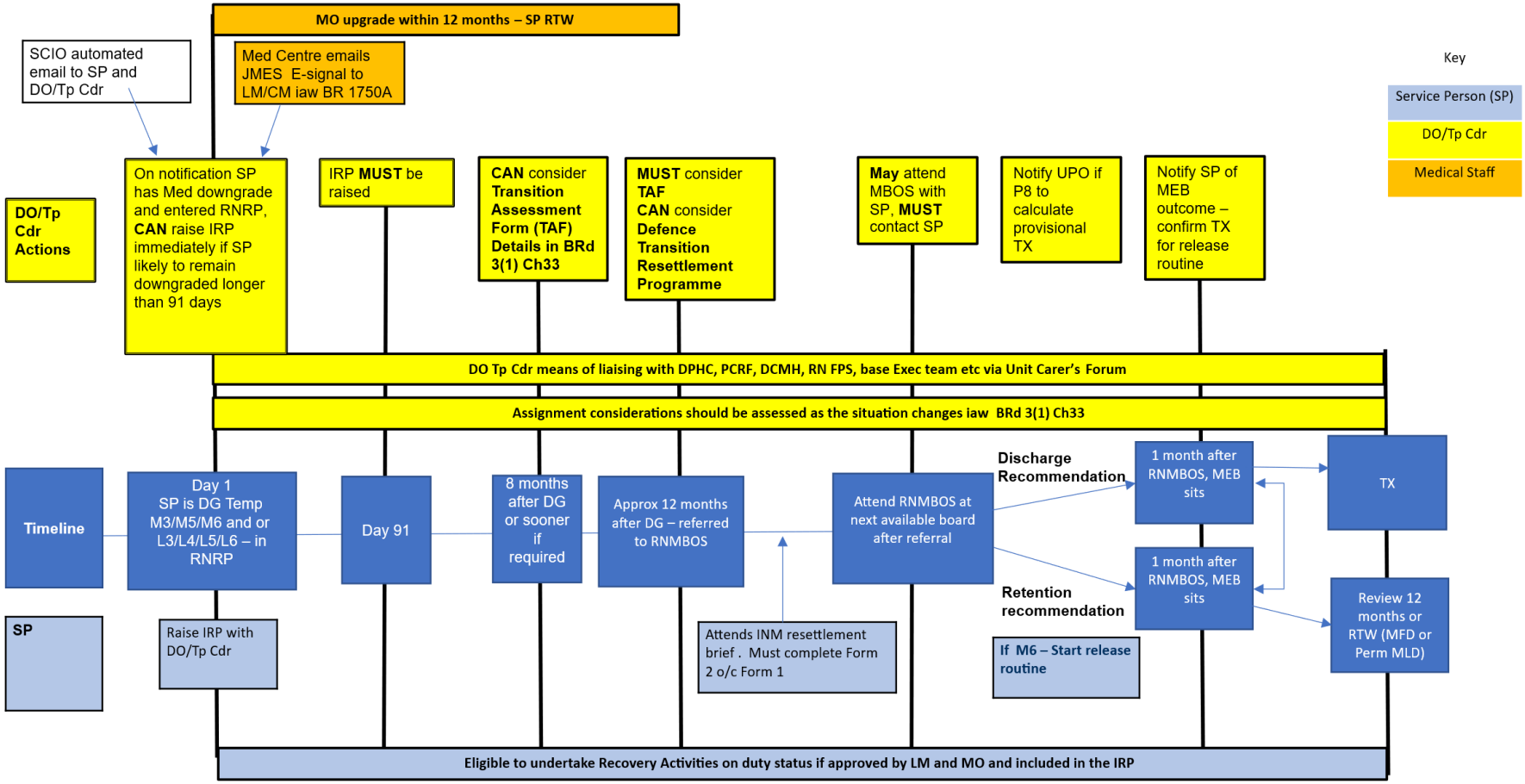
c. For those PRD who face significant barriers to employment, a Specialist Employment Consultant (SEC) may be available through the CTP (Assist) programme; the NRIO will be able to advise.

d. When discharge on medical grounds is likely, attendance on one of the Core Recovery Events (CREs) 2 or 3 may be appropriate. Hosted at the PRCs in Colchester, Edinburgh, Tidworth and Catterick[30], CRE 2 is a ten day course that focuses on employment and realistic vocational options whilst CRE 3 is a five day course designed for PRD who have been assessed as requiring extra support in transition to civilian life as a result of their injury or illness. These courses do not replace CTP and CTP (Assist), which should always be considered. Full details of CRE courses are at Annex 33E.

[27] https://modgovuk.sharepoint.com/sites/defnet/HOCS/Documents2/JSP100_Part2.pdf
[28] JSP 534 Section 6.
[29] JSP 534 Section 6.
[30] Course dates are published in DINs and on the ARC SharePoint site:
https://modgovuk.sharepoint.com/teams/14540/Pers/ARC/ARC_Engagement_Portal/SitePages/ARC_Course_Applications.aspx

ANNEX 33A

ROYAL NAVY RECOVERY PATHWAY (RNRP) OVERVIEW



Note 1. The IRP can be raised from day 1 but must be raised by Day 91[1]. This is to ensure line management and SP are both aware and discussing the recovery pathway; for some, a full assessment may seem un-necessary but you are encouraged to review it to identify and mitigate any issues as early as possible.

Note 2. Whilst referral to RNMBOS may be a source of anxiety, understanding and preparing for all potential outcomes will mitigate this. The Medical Employment Standards Gateway contains useful information for both the SP and their line management MES Gateway (sharepoint.com)[2]. If a recommendation for medical discharge is possible, preparation is key to a smooth transition to civilian life. Resettlement can be accessed ahead of the RNMBOS and should be considered from 8 months after initial downgrade (or earlier if appropriate). More guidance is within JSP 534.

Note 3. Veterans Services provides ongoing support, guidance and information to service leavers and their families on issues that will endure beyond discharge. Veterans Services support is available irrespective of the reason for discharge and is available to regular, reservists and their families. Referrals into Veterans Services are made using the Defence Transition Referral Protocol (DTRP) detailed in JSP100. This can be made on behalf of the SP or family member by any responsible tri-service military authority, or by the individual SP or family themselves through self-referral. Integrated Personal Commissioning for Veterans (IPC4V) Framework is a personalised care approach for the small number of Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions resulting from injury whilst in Service to ensure they are effectively cared for and supported as they transition to civilian life and beyond. Individuals who are eligible for IPC4V are proactively identified by medical staff while they are on the Defence Recovery Pathway. Further information is available in JSP 100[3] and JSP 661[4] Chapter 4.

Note 4. Preparation for, attendance at and post RNMBOS actions are explained in BR 1991 Chapter 8. The DO or Tp Cdr can use discretion as to whether the SP is accompanied to RNMBOS in conjunction with the SP's preference. Those attending in person will receive a letter on the day containing the Board's recommendations; this is to be given to the DO or Tp Cdr by the SP. Those considered in absentia will be contacted by phone and followed up with an email. The DO or Tp Cdr needs to take appropriate actions according to whether the person has been recommended for medical discharge or retention in accordance with article 0816 of BRd 1991.

Note 5. Individuals who have been recommended for medical discharge by the RNMBOS are to undertake their release routine and proceed on leave immediately following the RNMBOS in the expectation that the RNMEB will ratify the recommendation to medically discharge the individual in accordance with article 0826 of BRd 1991.

Note 6. Unit Case Conferences and N1 forums are to be convened in accordance with Annex 24B of BRd 3(1).

---

[1] The reason for this discretionary period is that some people will make a full recovery within 90 days and therefor do not need a full IRP.
[2] MES Gateway
[3] JSP 100 - Defence Holistic Transition Policy.
[4] JSP 661 - Health and Welbeing.

Note 7. Assignment considerations should be made throughout the time the SP is in the RNRP; it is dependent on many variables and guidance is within para 3306.

Note 8. Options available to the RN Medical Employability Board (MEB) are detailed in article 0821 of BRd 1991. One option is where the RNMEB is satisfied, on employability grounds, an individual can no longer be fully and gainfully employed within the JMES recommended for them by the RNMBOS. Where medical discharge is agreed or decided upon by the RNMEB, individuals will be expected to conduct their release routines immediately thereafter and commence leave.

Note 9. SP are eligible to undertake recovery activities from day one of the RNRP but only if the activity is agreed by Chain of Command, Medical Officer and it is recorded in the IRP. Information on recovery activities is available via the Recovery and Resilience Margins intranet site[5]. UTS personnel only eligible to undertake RN delivered recovery activities; access to Defence Recovery Activities subject to individual circumstances as approved by RRM HQ.

[5] modgovuk.sharepoint.com/teams/62286/SitePages/Recovery-Courses.aspx?csf=1&web=1&e=sTqROO

ANNEX 33B

WORKFORCE RESILIENCE AND TRAINING MARGIN ORGANISATION CONTACT DETAILS

PSGs	
Position	**Internal Email**
Portsmouth – MA7A PID - 1429940	
OIC	NAVY NBCP-CoB-PSG OiC
EWO	NAVY NBCP-CoB-PSG DivSptGrp Mgr
Devonport – MA7A PID – 2163014	
OIC	NAVY NBCD-PSG OIC
EWO	NAVY NBCD-PSG EWO
Faslane – MA7A PID – 1387344	
OIC	NAVY SUBFLOT-PSG OIC
EWO	NAVY SUBFLOT-PSG EWO
Culdrose – MA7A PID - 1129494	
WO	NAVY CU-EXEC PSG WO
Yeovilton – MA7A PID - 1112938	
WO	NAVY YEO-EXEC PSG WO

RTs	
40 Cdo – MA7A PID - 1391125	
WO	3CDOX-40CDO LOG HQ 2IC
42 Cdo – MA7A PID - 1391134	
WO	3CDOX-42CDO KANGAW OC
45 Cdo – MA7A PID - 1391139	
WO	3CDOX-45CDO BASE 2IC
CLR	
WO	NAVY CU-EXEC PSG WO
Hamworthy Barracks – MA7A PID - 2138244	
Local arrangements	
CTCRM – MA7A PID - 1131840	
PRDWO	NAVY TRG CTCRM-HQ WISWO
RNRC Hasler – MA7A PID – 1629650	
CSM	NAVY NPS-HASLER CSM

ANNEX 33C

ASSIGNMENT CONSIDERATIONS FOR PERSONNEL ON THE RNRP

1. When a Service Person (SP) enters the RNRP:

a. **Step 1 - JMES Change.** JMES change to Temp JMES L3, 4, 5 or 6 or M3, 5 or 6. As soon as a Service Person's (SP) JMES is changed by a Medical Officer (MO), regardless of how long this is expected to be, they should inform their LM. Formal notification will follow from DPHC (via various means dependant on location) and an automatic email notification will also be sent to the individual and LM. The SP and LM are to discuss the JMES and any medical limitations (MEDLIMs) to fully understand any personal and employment considerations that may be required immediately. Further guidance on JMES and MEDLIMS is in JSP 950. Take advice from your Medical Branch personnel as required.

b. **Step 2 - Employment Considerations.** The LM needs to consider the requirements of the role of the SP. There are no set criteria for remaining in role or not; the LM needs to consider the following (non-exhaustive list): the current JMES and MEDLIMs including the review date; the clinical pathway including most likely timelines; unit programme/operational output; individual's role and how much of it they can conduct; personal considerations etc. If it is reasonable for the SP to stay in their role, undertake a risk assessment as required and make reasonable adaptations to tasking and/or the environment. As the situation develops, re-assess this step and act accordingly, either continuing to support recovery in role or moving to Step 3 below.

c. **Step 3 - Assignment Considerations.** If the JMES review is in 3 months or longer and remaining in role is untenable for this or any other reason, the SP, LM and Career Manager (CM) are to discuss appropriate alternatives. For personnel with a Temp JMES of M6 for 3 months or more, strong consideration should be given for assignment to a Workforce Resilience and Training Margin (WRTM) organisation to minimise impact on the current unit and afford the SP optimal divisional support[1]. If there is a suitable Workforce Requirement driving position available, this should be considered before assignment to a medical margin (MA7A). If no alternative Workforce Requirement driving position is available, the LM, SP and CM are to discuss assignment to a medical margin within one of the following (WRTM) organisations:

(1) **PSGs in:** HMNB Devonport, Portsmouth and Clyde, RNAS Culdrose and Yeovilton.

(2) **RTs in:** 40, 42, 45 Cdo, CTCRM, CLR, and Hamworthy Barracks.

2. In determining which organisation is the most appropriate, LM and CM are to consider the following (non-exhaustive list):

a. Location of optimal clinical support (established clinical relationships, specialist support etc).

[1] Individual circumstances will always prevail but long term ill-health that prevents employment in any maritime environment (JMES M6) is usually best managed in a WRTM organisation.

b. Opportunities for temporary employment (e.g. RM employability in a Cdo unit, AET employability on an air station, SM employability onboard or shoreside etc).

c. Support network of SP (closest location of family and/or friends etc).

d. SP preference.

e. Potential long-term outcome (likelihood of returning to full Service or transition to civilian life - important to consider without assumption or prejudice).

f. Any reason not to assign to an area (assignment restrictions due to ongoing investigations etc.).

3. Once the most appropriate WRTM organisation is identified, the CM should discuss this and seek agreement with the relevant OC (or nominated representative at Annex 33B) and refer to the current RNTM for PSG/RT joining instructions. In all circumstances where a SP is assigned from their current role, a full divisional handover should be conducted to the new unit iaw BRd 3(1) 2113 and 2119 and consider the following:

a. An assignment to a medical margin will often be short notice and un-planned. LM should consider requirement for an SJAR/OJAR in accordance with JSP 752.

b. Summary of events preceding assignment if relevant.

c. Any ongoing administrative or disciplinary action (warnings, MAAs, MPAR, CW candidature, branch transfer applications ongoing, disciplinary investigations, assignment restrictions etc.).

d. Any other relevant issues either professional, domestic, or otherwise.

4. The CM is responsible for ensuring this decision is recorded in CM notes, to include names of LM and WRTM POC with whom the case was discussed and reason for the decision. No-one should be assigned to MA7A without prior agreement of the relevant organisation and without the SP's knowledge.

Step 4 – Case Conference. In circumstances where the case is either deemed clinically complex, significant, or agreement isn't achieved in LM/CM/WRTM OC discussion, the case is to be raised by the WRTM OC to SO1 RRM who will arbitrate on which WRTM organisation medical margin is the most appropriate, including consideration to raise a formal case conference for potential assignment to the RNRC Hasler, based within HMNB Devonport and structured to support the most medically complex personnel within the RNRP. Cases where a case conference is required are to be referred to SO1 RRM using the format at Appendix 33C1 (editable version in BRd 3(1) forms section). The case conference will be convened, and outcome recorded by RRM HQ with CM notes also annotating the outcome (for both assignment to Hasler and circumstances where an alternative unit was agreed upon).

5. Ongoing Recovery Pathway Support. Regardless of assigned unit or location, the same level of support and opportunity is offered to all personnel in the RNRP. There are various considerations to be made at discreet stages but due to the individual nature of recovery, these may come at different times and to varying degrees. The Individual Recovery Plan (IRP) at Annex 33D (editable version found in forms section at the end of BRd 3(1)) is to be used by personnel within the RNRP to guide their own pathway and Line Managers/Divisional Officers and Troop Commanders are integral to this process. Recovery may mean living with a new normal, it may mean a new career pathway (either in or out the Service), it will invariably impact the family and/or support network of the person affected, and the Royal Navy is committed to enabling the best outcome possible.

6. This process stops at the point of establishing a person's assignment whilst they undergo recovery but can be revisited as and when the situation changes.

APPENDIX 1 TO ANNEX 33C

CASE CONFERENCE PROCESS – COMPLEX CASES

1. After following the Steps in Annex 33C, if a Case Conference (CC) is deemed appropriate, a request is to be submitted by the LM using the form below, to NAVY PEOPLE-PS RRM DIVS WO. A case conference will be convened at the earliest opportunity. The CC will be chaired by SO1 Recovery and Resilience Margins HQ or nominated representative.

2. The CC request should include the contact details of those personnel required to attend. As a minimum, the individual's clinical lead and DO/Tp Cdr are required to ensure the SP is properly represented. RRM HQ will facilitate the CC and send out meeting requests to the personnel identified on the CC request. The unit is required to notify the SP to determine if they wish to attend the CC (they will be included in the first part and asked to step away whilst further discussions are held).

3. To ensure the patient is appropriately represented, all facets of care (e.g. clinical welfare, physio, divisional, etc.) should attend the CC if possible. If key personnel are unable to attend the CC, they are to ensure that a suitably informed and empowered representative from the parent unit is available. In exceptional circumstances, where attendance in person is not possible, written evidence supporting the CC is to be forwarded to the RRM HQ in good time.

4. If a patient is under the care of DCMH, representation at CC is strongly recommended. Failing this, clinical staff must ensure that the DCMH recommendation for the patient's outcome and recovery needs is represented by a doctor at CC. Also, should DCMH recommend the re-assignment of a patient at CC, given the importance of such a recommendation, this must be included in DMICP notes.

5. The case conference will open with introductions on all attendees followed by the SP being invited to summarise their situation, sharing as much or as little as they wish. Attendees will be given the opportunity to ask questions of the SP before they leave. The format will then take clinical, professional and personal points into consideration dependant on the individual case. The final decision is made by SO1 RRM and this is to be recorded by CM and RRM HQ and conveyed to the SP by their LM as soon as possible after the CC. The current unit LM is to ensure the relevant CM is aware of the decision as soon as possible to arrange the Assignment Order to the relevant MA7A (iaw Annex 33B). The Work force Resilience Training Margin (WRTM) organisation where the person is to be assigned is to arrange a handover/joining routine as soon as possible.

ROYAL NAVY RECOVERY CASE CONFERENCE REQUEST FORM

ROYAL NAVY RECOVERY CASE CONFERENCE REQUEST FORM
(Downloadable version available in BRd 3(1) Forms Section)

ANNEX 33D

INDIVIDUAL RECOVERY PLAN (IRP)

INDIVIDUAL RECOVERY PLAN (IRP) *(Downloadable version available in BRd 3(1) Forms Section)*

ANNEX 33E

CORE RECOVERY EVENTS AND THE RECOVERY ACTIVITIES PROGRAMME

1. Introduction

a. Recovery Events are available to all personnel on the RNRP and are designed to complement the clinical pathway and assist the Service Person in their recovery whilst in role, return to work, or transition to civilian life. The courses take place all over the country and aim to be as broad and inclusive as possible. They are delivered via the Defence Recovery Centres, by external providers (commissioned and/or assured by the RRM HQ) or other in-Service providers.

b. All RN SP on the RNRP are to have an Individual Recovery Plan (IRP) from at least day 90 of meeting the entry criteria which synchronises and schedules activities appropriate to an individual's recovery; it should record the progression of an individual towards their recovery goal/outcome as well as providing a diary of recovery activities. Recovery activities form a key part of the IRP and eligible personnel are to be encouraged to engage. No activities are mandatory however once agreed in an IRP, it is a duty to attend.

2. Suitability

Before any recovery activity/event is commenced, agreement with CoC is required to ensure activity/course is suitable in accordance with the SP JMES codes and any other competing factors. SP and their DO/LM should aim for a reasonable balance, particularly for those personnel with a Temp JMES of M5 or above who are able to complete tasking/undertake a role in the Maritime Environment.

3. Recovery Activities Programme

Adaptive sport, wellbeing activities, vocational experiences and activity-based recovery courses are available. A full list of courses available can be found at RN Recovery Programme[2]. Individuals on the RNRP are encouraged to tailor their IRP according to their personal preferences and needs in discussion with their DO/LM. As a guide however, the following Core Recovery Events (CREs) are summarised for consideration at key stages of the Recovery Pathway:

a. **Recovery Foundation.** The Foundation Course is a one-week introduction to the Recovery Pathway. It establishes early understanding, assesses needs, and supports initial wellbeing and resilience. Personnel who wish to gain a greater insight into how to design and manage their own recovery would benefit most from attending this course. More information is available online[3].

[2] https://modgovuk.sharepoint.com/teams/62286/SitePages/Recovery-Courses.aspx?csf=1&web=1&e=sTqROO%20
[3]https://modgovuk.sharepoint.com/:w:/r/teams/62286/_layouts/15/Doc.aspx?sourcedoc=%7BEF0E371D-068D-4A72-9DB5-64E5FDFE901B%7D&file=20250609-PRC_Tidworth_Foundation_JIs_V4.doc&action=default&mobileredirect=true

b. **Recovery Transition.** This 10-day CRE prepares personnel on the RNRP for transition from military to civilian life and focuses on employment while examining realistic vocational options. Personnel must be registered for Resettlement and have completed a Resettlement Advisory Brief (RAB) prior to attendance. Core modules include career planning, financial management, housing, and vocational preparation. Attendance is especially recommended for SP lacking clarity in future career, housing or financial planning. More information can be found online[4]. Personnel are entitled to access resettlement ahead of attendance at an RNMBOS; Annex 33G details the application process including consideration of additional support via a Specialist Employment Consultant for those facing significant barrier to future employment.

c. **CTW+.** This CRE is an alternative to the regular Career Transition Workshop (CTW) available during Resettlement. This five-day course is aimed at those personnel with significant barriers to employment and who are in need of additional support.

4. Recovery Managers

For any queries on what recovery activities may suitable, when to undertake them, how to access them or any other query, personnel in the RNRP or their DO/LM can contact one of the Naval Base PSG Recovery Managers for guidance and advice NAVYPEOPLE-PSRECOVERYPROG@mod.gov.uk.

[4]https://modgovuk.sharepoint.com/:w:/r/teams/62286/_layouts/15/Doc.aspx?sourcedoc=%7BC0116B1C-611F-4A89-81F4-6DE9B32F4D0B%7D&file=20251104-Tidworth_Transition_JIs_V5.doc&action=default&mobileredirect=true

ANNEX 33F

PARTICIPATION IN CORE RECOVERY EVENTS AND ACTIVITIES

References:

A. JSP 419 - Adventurous Training in the UK Armed Forces
B. JSP 765 - Armed Forces Compensation Scheme
C. JSP 661 – Health and Wellbeing
D. BRd 2 – The King's Regulations for the Royal Navy

1. Introduction. Participation in structured Core Recovery Events (CRE) and Royal Navy Recovery Activities is a core component of the RN's commitment to holistic recovery. These activities offer meaningful support to those recovering from injury or illness, and are integral to the development of resilience, psychological wellbeing, and social integration.

2. Scope and Purpose. This annex outlines eligibility and administrative provisions for RN personnel taking part in Recovery Activities endorsed by the Recovery and Resilience Margins HQ (RRM HQ). It reinforces the entitlement to duty status and duty travel and provides guidance on the roles of the parent unit in supporting attendance.

3. Recovery Activities

a. Recovery Activities are coordinated by the RRM HQ and Defence Recovery Capability. These activities are distinct from recreational or sporting events. Their primary aim is to support the SP recovery journey, in accordance with the individual's Recovery Plan and clinical guidance.

b. Activities are designed to be as inclusive and accessible as possible for all personnel on the Recovery Pathway; best efforts will be made for individual needs and adaptations required but cannot be guaranteed for all activities.

4. Eligibility

a. Participation is open to all RN personnel on the Trained Strength (GTS) who meet the eligibility criteria for the Royal Navy Recovery Pathway (RNRP) i.e. Temporary JMES of M3/5/6 or L3/4/5/6, regardless of where they are assigned. Untrained Strength (UTS) who meet the RNRP JMES criteria AND are assigned to the medical margin within a WRTM organisation (the Personnel Support Groups (PSGs), Recovery Troops (RTs) or Royal Navy Recovery Centre (RNRC) Hasler) are eligible to undertake RN Recovery Activities only; they are not eligible to undertake Defence Recovery Capability delivered CRE or other activities delivered at the Personnel Recovery Centre (PRCs). If a Divisional Officer/Troop Commander believes exceptional consideration should be made for a UTS SP, application is to be made to SO1 RRM.

b. Personnel who have been assigned a medical grading of Permanent M6 (P8) following an RNMBOS remain eligible to participate in authorised recovery activities up to their Termination Date[1].

c. Personnel remain eligible to participate in Recovery Activities until they are no longer in the RNRP i.e. they are fully medically upgraded and return to work, they are given a permanent JMES and return to work or they leave the Service.

d. Participation must be supported by:

(1) The Individual's Recovery Plan (IRP)

(2) Approval from the Divisional Officer/Troop Commander

(3) Confirmation that participation is clinically appropriate.

5. Administrative and Travel Entitlements

a. Personnel participating in Recovery Activities endorsed and organised by the RRM HQ are to be considered on duty for the duration of the course in accordance with BRd2 Ch 87 Annex 87A 1.

b. The nature, breadth and scope of Recovery Activities means it is impossible to articulate every scenario that may lead to a SP being considered 'Off Duty' whilst undertaking an RRM HQ endorsed activity. In general, 'On Duty' status covers the travel to, from and between authorised activity, the recognised activity itself and the administrative tasks directly related to that activity. For example, but not limited to: cleaning or preparing kit and equipment, shopping for rations and attending planning meetings. Social events and leave will routinely be considered as periods of 'Off Duty'. However, it is recognised that some Activities may require in-country acclimatisation or rest days/hours between periods of specific activity. These should be captured within the Admin Instructions and would be considered 'On Duty'. The Admin Instruction does not require an hour-by-hour breakdown but must contain sufficient detail for participants, and the approval authorities, to clearly understand which occasions are considered to be 'Off Duty'. When briefing participants, they should be reminded that duty status is not determinative of liability in common law. As such their individual actions or behaviours, whether they are deemed as 'On' or 'Off duty', would be taken into consideration in the event of any compensatory or liability claim and, while it cannot be mandated, they are strongly advised to ensure they have adequate personal insurance for the duration of the Recovery Activity.

c. In accordance with JSP 752, Chapters 05 and Chapter 06, Sections 7 - 10, eligible personnel are entitled to claim duty travel when attending an authorised Recovery Activity. The specific entitlements applicable will be promulgated via the relevant administrative instruction.

[1] JSP 534 Sect 16

d. Permitted claims include:

(1) **Travel.** Travel at public expense from the individual's Permanent Duty Station (PDS) or Registered Residence to and from the location of the Recovery Activity within the UK.

(2) **Subsistence Allowance.** When accommodated in commercial hotel facilities within the UK or overseas, personnel are eligible to claim subsistence in accordance with the rates and limitations set out in JSP 752.

(3) **Cash in Lieu of Rations (CILOR).** May be claimed where self-catering accommodation is provided, and Service messing is not available or not appropriate.

e. The cost of travel and subsistence for participation in Recovery Activities is to be met by the participant's parent unit using the appropriate Unit Identification Number (UIN). Where the parent unit is unable to meet these costs within existing resources, a request for additional funding is to be submitted to Navy Finance (Navy FD-Fin Fleet Liaison) for a TDTS Budget uplift.

f. If attending a Recovery Activity as a staff member to enable delivery or conduct assurance on behalf of the RRM HQ, you are entitled to claim T+S using the RRM HQ UIN N6030K.

6. Governance and Record Keeping

a. All Recovery Activity attendance must be documented within the individual's Recovery Plan and noted by their Divisional Officer or equivalent.

b. Personnel are to ensure that a Budget Control Form (BCF) is completed and submitted to their Unit Pay Office (UPO) prior to undertaking any duty travel.

c. The effectiveness and appropriateness of Recovery Activities should be regularly reviewed as part of the individual's Recovery Plan and, where applicable, discussed at case conferences or board reviews (e.g., RNMBOS).

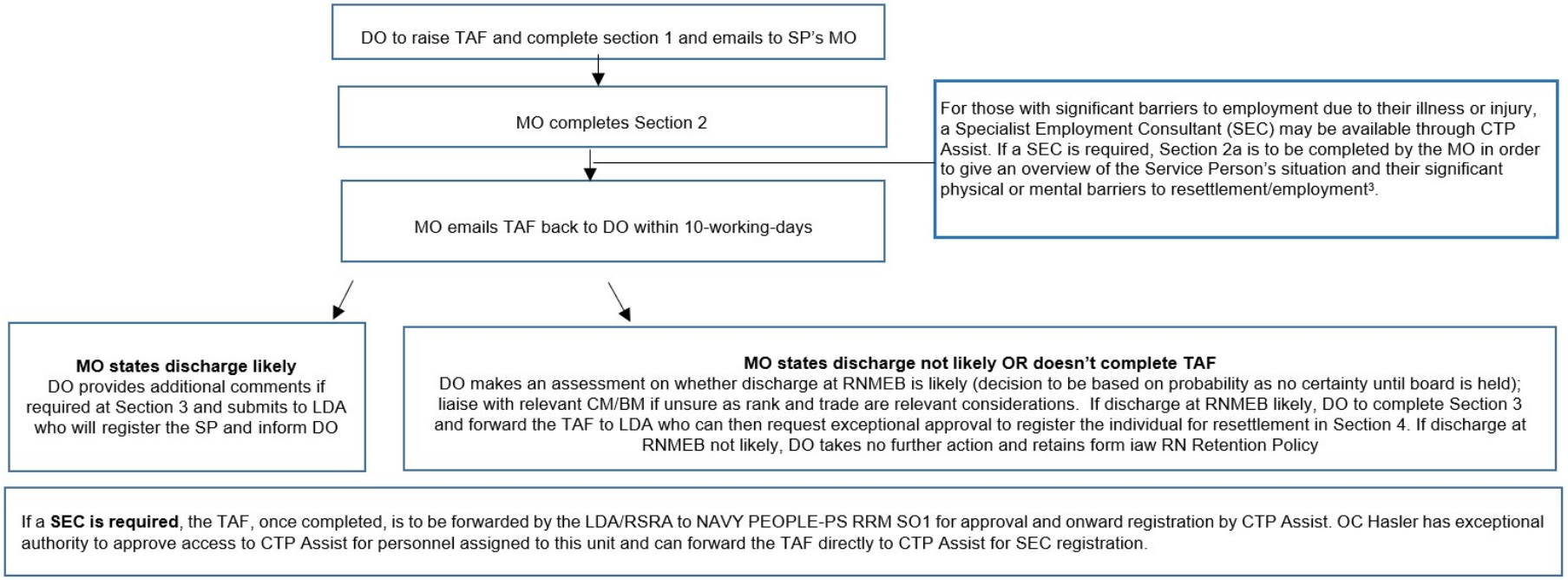
ANNEX 33G

TRANSITION ASSESSMENT FORM

TRANSITION ASSESSMENT FORM *(Downloadable version available in BRd 3(1) Forms Section)*

A Transition Assessment is to be completed for ALL personnel prior to their attendance at RNMBOS[1]. The process is outlined below[3].

Figure 33G-1. RNMBOS Process



[1] The TAF can be raised prior to the MO referral to RNMBOS if DO/Tp Comd deem it appropriate and in the individual's best interests or at the point of referral to RNMBOS. Rank/trade/nature of condition etc to be considered by the DO/Tp Comd in assessing the appropriate time for registration.
[3] When compiling the TAF, only information sufficient to inform a resettlement assessment is to be included noting Caldicott Principles and the Data Protection Act (DPA).

ANNEX 33H

NAVAL RESERVES RECOVERY PATHWAY

1. Preamble

a. As Defence moves towards the Whole Force Concept, the use of Maritime [1] to fill liability driving positions and work alongside their regular counterparts will increase. To support the rehabilitation and recovery of Personnel on Recovery Duty (PRD[2] Reserves Personnel (RP), they are to be managed and supported through the Royal Navy Recovery Pathway (RNRP).

b. Defence Primary Health Care (DPHC) is responsible for the delivery of Occupational Health (OH) and Rehabilitation to all reserves, irrespective of Terms and Conditions of Service[3,4], and is to provide OH assessments to establish the Joint Medical Employment Standard (JMES) to inform the employability and deployability of RP.

c. OH assessments serve to inform the Chain of Command (CoC) of an individual's health and deployability and protect those who are PRD by identifying what they can and cannot do. Reservists are required to inform their CoC of any condition that affects their ability to carry out their duties (although there is no requirement to disclose the details of any condition or injury) and attend a military medical assessment.

d. Where an individual has been awarded a JMES below Medically Fully Deployable (MFD), there is a requirement to have that grading reviewed annually for permanent grades and at least every six months for temporary grades.

e. Reservists attending with new or changed conditions must provide relevant documentation from their GP/specialist in order to allow the assessing doctor to make an informed decision. Where the assessing doctor does not feel that they have sufficient detail to award an accurate grade, they may write to the reservist's civilian GP to request further information. Reservists must be aware that attending a medical without sufficient documentary evidence will result in the award of a temporary JMES that may prevent them from training or employment.

f. In order to access OH assessments, all reservists are required to have a fully summarised Defence Medical Information Capability Programme (DMICP) record.

---

[1] Maritime Reserves (MR) and Royal Fleet Reserves (RFR)
[2] Awarded a Joint Medical Employment Standard (JMES) of M5 or M6.
[3] This includes Sponsored Reserves and URNU personnel but does not extend to cadets or adult instructors in the Cadet Forces.
[4] 2017DIN01-096.

2. Recovery Support – This policy is currently under review

a. All reservists with a JMES that fits the RNRP entry criteria are to have an Individual Recovery Plan (IRP) (Annex 33C) drafted after assessment by DPHC OH. This will allow the individual and unit executive to discuss the implications of the injury or illness with regards employability and deployability and signpost any support that may be required using the HARDFACTS[5] assessment.

b. Reservists with a JMES that fits the RNRP entry criteria are to be managed, in the first instance, by their Parent/Employing Unit. Should recovery not be progressing, the Unit is to convene[6] a Carers' Forum or other Multi-Disciplinary Team (MDT) to assess the case and future recovery and rehabilitation needs which, in most circumstances, will be provided by the NHS.

c. Should the reservist be injured on duty, evidenced by a MOD Form 510 or equivalent, the individual is entitled Service rehabilitation support. There are two potential avenues for treatment; RP (and any regular staff attached to reserve units) may receive care through the Reserve Rehabilitation Contract or at their local Primary Care Rehabilitation Facility (PCRF)[7].

d. The recovery of those RP injured on duty should be managed by the Parent/Employing Unit or as directed by the Carers' Forum or MDT. Should further support be required SO1 RRM is to be consulted to consider appropriate assignment considerations.,

e. Whilst being managed by the Parent/Employing Unit, support, advice and guidance may be sought from RRM HQ and specialist recovery units e.g. PSGs and Recovery Troops[8]. Assignment to a specialist recovery unit will only take place as directed by the Case Conference taking into account the special circumstances of the case and complexity, depth and breadth of need.

f. The use of recovery courses and activities (Annex 33E, Annex 33F) may be appropriate to aid recovery and should be considered for all reservists.

g. In order to attend a recovery activity, a Medical Risk Assessment is required to ensure that the activity/course selected is appropriate, does not impact rehabilitation and is conducive to recovery.

h. Any costs incurred in attending recovery courses or activities lie where they fall i.e. with the Parent/Employing Unit[9]. All RP attending courses/activities must be on designated 'recovery' duty and have appropriate funding agreed e.g. man training days available.

---

[5] **H**ealth, **A**ccommodation and **R**elocation, **D**rugs and Alcohol, **F**inance and Benefits, **A**ttitude, Thinking and Behaviour, **C**hildren and Family, **T**raining, Education and Employment, **S**upporting Agencies.
[6] For FTRS personnel, the FTRS CM is to be included.
[7] 2017DIN01-047.
[8] Referred to as 'Unit Assist'.
[9] As for Regular PRD personnel.